

**Department of Veterans Affairs (VA)
Children of Women
Vietnam Veterans (CWVV)
Health Care Benefits Program**

This handbook contains important information on CWVV health care benefits. Please read it carefully prior to using your CWVV benefits.

Changes that take place between printings of this handbook are published in the form of Handbook Changes. Handbook Changes are mailed to each beneficiary, so it is very important that address changes be reported promptly to VA's Health Administration Center. Please read all Handbook Changes carefully and file them with your handbook until it is republished.

There is no scheduled republishing date for this handbook. The next edition will be published based upon the volume and extent of changes.

Check our web site for the latest information at www.va.gov/hac.

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Assistance

- **General Information:**

Phone: 1-888-820-1756
E-Mail: cwvv.inq@med.va.gov
Mail: VA Health Administration Center
PO Box 469027
Denver, CO 80246-9027
Website: www.va.gov/hac

- **Preauthorization:**

Phone: 1-888-820-1756
E-Mail: cwvv.inq@med.va.gov
Mail: VA Health Administration Center
PO Box 469027
Denver, CO 80246-9027
Fax: 303-331-7807

CWVV

Health Care Benefit Program

Overview

In addition to monetary allowances and vocational training and rehabilitation, the Department of Veterans Affairs also provides VA-financed health care benefits to women Vietnam veterans' birth children who the Veterans Benefits Administration (VBA) has determined to have a covered birth defect.

This program covers those services necessary for the treatment of a covered birth defect and related medical conditions. You should be aware that this program is not a comprehensive health care plan and does not cover care that is unrelated to a covered birth defect.

The VA's Health Administration Center (HAC) in Denver, Colorado manages the CWVV health care program, including the authorization of benefits and the subsequent processing and payment of claims. Contact us if you have questions.

Application Process

Health care benefits are based on eligibility determinations made by the Denver VA Regional Office. You must first contact the Regional Office to initiate the application process. Call 1-800-827-1000.

Costs

There are no beneficiary co-payments or deductibles. VA is the exclusive payer for services provided to beneficiaries under this program and billing should be sent directly to the Health Administration Center. The determined allowable amount for payment is considered payment in full and the provider may not bill the beneficiary for the difference between the billed amount and the VA-determined allowed amount.

Contact the HAC

Phone: 1-888-820-1756
E-Mail: cwvv.inq@med.va.gov
Mail: VA Health Administration Center
PO Box 469027
Denver, CO 80246-9027
Website: www.va.gov/hac

Health Benefits

CWVW beneficiaries receive an identification card from the Health Administration Center. This card includes the beneficiary's name, Social Security Number (SSN), and effective date for health care benefits.

General Coverage:

This program only provides health care coverage for services and supplies that are necessary for the covered birth defect and associated medical conditions.

General Exclusions

- care as part of a grant, study or research program
- care considered experimental or investigational
- care that is not medically necessary or appropriate
- care unrelated to a covered birth defect
- drugs not approved by the F.D.A. for commercial marketing
- services provided outside the scope of the provider's license or certification
- services rendered by providers suspended or sanctioned by a federal agency
- services, procedures or supplies for which the beneficiary has no legal obligation to pay, such as services obtained at a health fair

Preauthorization Requirements

While most health care services and supplies do not require approval in advance (preauthorization), some do.

- Preauthorization is **NOT** required for routine health care services and supplies that are clearly related to the treatment of the covered birth defect and associated medical conditions.
- Preauthorization **IS** required for:
 - attendants
 - dental services
 - durable medical equipment (DME) with a total rental or purchase price in excess of \$300.00
 - mental health services

- substance abuse treatment
- training of family members
- transplantation services
- travel (other than mileage for privately owned automobiles for local travel)

Note: When in doubt, contact the HAC.

How to Request Preauthorization

You can obtain preauthorization from the Health Administration Center by telephone or FAX.

by phone: 1-888-820-1756

by Fax: 1-303-331-7807

To request preauthorization, include the following:

- beneficiary's name
- beneficiary's Social Security Number (SSN)
- description of service requested to include procedure and diagnosis codes
- estimated cost (if known)
- medical justification for services requested
- name, address, and telephone number of the provider who will actually furnish the requested services
- the anticipated date of service
- veteran's name
- veteran's Social Security Number (SSN)

If the service is not urgent, you can mail your preauthorization requests to:

VA Health Administration Center
PO Box 469027
Denver CO 80246-9027

Ambulatory Surgery

Ambulatory surgery is performed on an outpatient, walk-in, or same day basis in an appropriately equipped and staffed facility. Surgery is usually conducted under general anesthesia with no overnight stay required. CWWV coverage of ambulatory surgical procedures depends on where the surgery takes place. Ambulatory surgical procedures performed in a hospital are covered when medically necessary for the covered birth defect and associated conditions. Certain procedures performed in a freestanding ambulatory surgical center (not in a hospital) are covered so long as the procedure is approved by Medicare to be performed in a free-standing ambulatory surgery center (ask your provider).

What **IS** Covered:

- ancillary services (i.e., x-rays, lab tests, etc.) in an approved hospital
- facility service
- professional fees such as physician services
- surgical procedures

What is **NOT** Covered:

- surgical procedures performed in a free-standing ambulatory surgical center (outside of a hospital) that are not Medicare approved
- ancillary services or facility fees in a free-standing ambulatory surgical center (considered inclusive in the surgical fee)

Attendants (Preauthorization is required)

A physician or nurse may be authorized to accompany the beneficiary when medically necessary due to the beneficiary's physical or mental condition related to the covered birth defect. In this case CWWV will provide reimbursement for professional fees and associated travel costs when the service has been preauthorized.

A relative or friend of a beneficiary may act as an attendant provided it is medically necessary due to the beneficiary's physical or mental condition related to a covered birth defect and the relative or friend can provide the appropriate level of care. In this case, reimbursement for associated travel costs will be made when the service has been preauthorized. Fees for the attendant's time are not reimbursable.

Dental Services (Preauthorization is required)

Dental care is not a covered benefit unless necessary for the treatment of a covered birth defect or an associated medical condition.

Durable Medical Equipment (DME) Preauthorization is required for any item bought or rented that exceeds \$300.00 in total cost.

We define DME as equipment that is ordered by a physician for the specific use of the beneficiary and:

- can withstand repeated use,
- improves the function of a malformed, diseased, or injured body part or prevents further deterioration of the medical condition,
- is medically necessary for the treatment of a covered birth defect or related medical condition(s),
- is appropriate for use in the home, and
- is used to serve a medical purpose (rather than for transportation, comfort, or convenience).

Durable medical equipment includes items such as wheelchairs, hospital beds, and ventilators.

Except in emergencies, DME items may be purchased by the HAC through a VA source at a discounted rate. Requests for preauthorization must have the doctor's DME order (prescription, or certificate of medical necessity) that includes:

- the anticipated duration of need for the item,
- the make, model number, cost, and if the item must be customized,
- a statement that describes the medical necessity

In the case of an emergency, immediate rental will be authorized for DME necessary for the covered birth defect from a local supply center until the equipment can be provided through the VA. In urgent need situations, such as a patient being discharged from the hospital to the home and requiring a hospital bed, preauthorization should be requested by phone.

What **IS** Covered (not all inclusive):

- customization, accessories, or supplies that are essential to

provide a therapeutic benefit and to ensure proper functioning of the equipment

- DME that is prescribed by a physician for the treatment of a covered illness or injury, provides the necessary level of performance, and is consistent with the FDA approved labeling for use
- duplicate item of DME when it is essential to provide a failsafe, in-home, life support system
- maintenance by a manufacturer's authorized technician
- repair and adjustment
- replacement needed as a result of normal wear or a change in the medical condition
- temporary rental when the purchased DME is being repaired
- vehicle wheelchair lift (detachable)

What is **NOT** Covered (not all inclusive):

- DME for which the patient has no obligation to pay
- exercise equipment
- hot tubs
- household and recliner chairs
- luxury or deluxe equipment (only the cost of basic equipment that meets the medical needs of the patient is covered)
- maintenance agreements/contracts
- modification to home or vehicle
- ramps
- repair and adjustment costs on rented/leased equipment (those costs should be included in the rental/lease agreements)
- spas
- sporting equipment
- swimming pools
- vehicle lifts that are non-detachable and/or manufactured for a specific vehicle that cannot be removed from one vehicle and used on another
- whirlpools

Home Care

Medical care, habilitative and rehabilitative care, preventive health services, and health related services furnished to an individual in the individual's home or other place of residence.

What **IS** Covered:

- treatment by an approved health care provider [physician, registered nurse, licensed practical nurse (LPN), licensed vocational nurse (LVN), therapist or home health aide] when the beneficiary is homebound or the condition is such that home care is medically indicated by a physician

What is **NOT** Covered:

- companion services
- day care (child or adult)
- homemaker services
- personal attendant (an individual who assists with activities of daily living such as cleaning, shopping, etc.)

Inpatient Services

An inpatient episode of care (more than 24 hours) is covered when medically necessary for the covered birth defect.

What **IS** Covered (not all inclusive):

- diagnostic tests and procedures
- patient-initiated second opinion consultation to determine the medical necessity of a service
- physician care/visits received in a hospital or other specialized facility for a covered diagnosis
- physician specialist consultations requested by the attending physician (consultation performed within three days of the surgery are not reimbursed separately)
- private room when medically necessary
- room and board
- semi private room
- skilled nursing facility care that provides care prescribed by, or performed under the general direction of a physician
- surgical assistant if required by the complexity of the surgical procedure being performed (must submit supporting medical documentation)
- surgical services

What Is **NOT** Covered (not all inclusive):

- custodial care
- domiciliary care
- halfway houses
- personal comfort items such as telephones and televisions
- retirement or rest homes
- services/supplies that could have been (and are) performed routinely on an outpatient basis
- staff consultations required by the policies of a hospital or other institute
- telephone consultation

Mental Health (Preauthorization is required)

Mental Health services are covered when medically necessary for treatment of the covered birth defect.

A proposed treatment plan is required that includes diagnosis (as listed in Diagnostic and Statistical Manual of Mental Disorders-DSM IV), modalities to be used, length of sessions, estimated length of treatment (frequency and number of visits), and the relationship of the need for treatment to the covered birth defect. A properly licensed and/or certified mental health provider must provide the services requested. In the case of an emergency mental health admission, the request for authorization should be made within 24 hours of admission, but must be made to us within 72 hours.

What **IS** Covered (not all inclusive):

- emergency admission related to the covered birth defect or associate conditions reported no later than 72 hours from the time of admission
- service by a mental health provider who is appropriately licensed and/or certified.

What is **NOT** Covered (not all inclusive):

- outpatient psychotherapy provided while a beneficiary is participating in an inpatient program
- services not related to a covered birth defect or related medical condition(s)

Orthotics

Orthotics are any appliance customized to assist in movement or to provide support to a limb and medically necessary for the covered birth defect.

What **IS** Covered:

- cervical orthosis
- lower limb orthotics
- spinal orthotics
- upper limb orthotics
- replacement when required due to growth or a change in condition

Pharmacy Services, Supplies, and Over-the-Counter Items

What **IS** Covered (not all inclusive):

- drugs and medications, administered by a physician or obtained by prescription
- drugs approved by the Department of Health and Human Services' Food and Drug Administration (FDA) for the treatment of the condition for which it is administered
- drugs prescribed by an authorized provider and dispensed in accordance with State law and licensing requirements
- drugs that are medically necessary and appropriate for the treatment of the covered condition for which it is administered
- expendable supply items such as catheters, colostomy or ileostomy sets and supplies, plastic or rubber gloves, skin preparations and powders for orthotic and prosthetic appliance wearers, urinals, leg or canister type urinary drainage supplies and incontinence supplies
- over-the-counter medications prescribed for the treatment of a covered birth defect or related medical condition(s)

What is **NOT** Covered (not all inclusive):

- drug maintenance programs where one addictive drug is substituted for another (such as methadone for heroin)
- drugs not approved by the FDA for commercial marketing
- drugs prescribed or furnished by a member of the patient's immediate family
- experimental/investigational (unproven) drugs
- group C drugs for terminally ill cancer patients (these medications are available free from the National Cancer Institute through its registered physicians)
- items such as bed linens, specialty garments, and clothing
- placebo injections and drugs

Prosthetic Services/Devices

What **IS** Covered:

- replacement of prosthesis when required due to growth or a change in the patient's condition
- replacement prosthesis when medically necessary
- surgical implants that have Food and Drug Administration (FDA) approval

What is **NOT** Covered:

- prosthetic devices categorized by the FDA as experimental/investigational (unproven)
- prosthetic devices unrelated to the covered birth defect

Rehabilitative Services

What **IS** Covered (not all inclusive):

- restoration of lost neuromuscular functions
- diagnostic or assessment tests and exams
- inpatient cognitive rehabilitation for a maximum of 65 calendar days
- occupational therapy
- osteopathic and chiropractic manipulative therapy
- parenteral and enteral nutrition therapies
- physical therapy
- speech pathology services

What is **NOT** Covered (not all inclusive):

- assisted living to include group home, apartments, etc.
- camps
- treatment for speech disturbance of a non-organic (psychiatric or emotional) origin
- vocational rehabilitation and training (this benefit is covered through the VA Vocational Rehabilitation and Employment Service. For information, please call 1-800-827-1000.)

Respite Care

Respite care is furnished by an approved health care provider on an intermittent basis for a limited period to someone who usually lives in a private residence when such care helps the person to continue to live in the private residence.

What **IS** Covered:

- care for up to 30 days in a calendar year for periods not to exceed 14 calendar days
- care provided by an approved health care provider
- care provided in a hospital, skilled nursing facility, intermediate care facility, nursing home, or private residence

What is **NOT** Covered:

- care provided by a relative, friend, or other person who is not licensed or certified within the State to provide medical services.

Training Family Members

(Preauthorization and certificate of completion is required)

What **IS** Covered:

- training for family members, guardians, and members of the child's household when required to provide in-home management of a covered birth defect or related medical condition(s)
- training in the use of an assistive technology device

What is **NOT** Covered:

- fees (wages) submitted by family members or other non-professional care givers for the service provided
- training provided at general meetings, annual meetings, conferences, and other such seminars

Travel (Preauthorization is required for travel outside of the commuting area)

What **IS** Covered:

- ambulance services when medically necessary and life sustaining equipment is needed or other means of transportation are contraindicated
- transportation expenses to and from approved health care providers within the commuting area (round trip transportation expenses include transportation from residence to the location of treatment)

What is **NOT** Covered:

- ambulance service when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends, or personal physician
- ambulance service when used in lieu of taxi service, i.e., to take the patient to the hospital for treatment/therapy when the use of an ambulance is not medically necessary en route; or when the patient's condition would have permitted use of regular private transportation whether or not the private transportation was actually available
- travel allowance (meals and lodging) for less than 12 hours (round trip); travel begins when the beneficiary leaves home and ends when the beneficiary returns home; time noted on claim forms should be consistent with the miles traveled based on a test of reasonableness
- travel by parents or other family members to visit the beneficiary
- travel outside the commuting area when services are available within the commuting area
- travel to attend general meetings, annual meetings, conferences, and other such seminars where the focus is on dissemination of general information relating to a covered birth defect or related medical condition(s)

Selecting Health Care Providers

Provider Guidelines

Beneficiaries may select the provider of their choice as long as the provider is an approved health care provider. The provider must be approved by the Centers for Medicare and Medicaid Services (CMS) formerly known as HCFA, Department of Defense TRICARE program formerly known as CHAMPUS, CHAMPVA, JCAHO, or may be a health care provider approved for providing services pursuant to a state license or certificate. A provider is not required to contract with the HAC, so the HAC does not maintain a list of providers.

Authorized Providers

Medical services and supplies are covered when received from these professional providers (not all inclusive). In the case of physician assistants, counselors, anesthetists, nurses aides, audiologists, therapists, etc., there is a requirement for a referral from the primary physician and that the services be supervised (overseen) by the physician.

- Anesthetist
- Audiologist
- Certified Marriage and Family Therapist
- Certified Nurse Anesthetist
- Certified Nurse Practitioner
- Certified Physician Assistant
- Certified Psychiatric Nurse Specialist
- Chiropractor
- Clinical Psychologist
- Clinical Social Worker
- Dentist (when services are preauthorized and a covered benefit)
- Licensed Practical Nurse
- Licensed Vocational Nurse
- Medical Doctor (MD)
- Occupational Therapist
- Optometrist
- Osteopath
- Pastoral Counselor
- Physical Therapist
- Physician (MD)
- Podiatrist

- Psychiatrist
- Physiologist
- Registered Nurse

Services from the following types of providers are not covered:

- Acupuncturist
- Naturopath

Provider Options

In addition to approved private providers, some services may also be obtained from VA health care facilities. Contact the VA in your area to see if they have space available to provide treatment. It's up to the local VA health care facility to decide if they can provide the care you need.

Claims

Mail claims for payment to:

**VA Health Administration Center
PO Box 469027
Denver, CO 80246-9027**

We recommend that you keep a copy of all claim documents submitted.

Forms

Providers should use a standard billing form (UB-92, HCFA 1500) to provide the required information as indicated below. Beneficiaries who are filing claims for reimbursement of out-of-pocket expenses, should use the HAC supplied form, Claim for Miscellaneous Expenses (10-7959e).

Required Documentation

All claims must contain:

Patient Identification

- full name (as it appears on identification card)
- social security number (SSN)
- address
- date of birth

Provider Identification

- full name and address, with zip code, of hospital or physician
- individual provider's professional status (M.D., Ph.D., R.N., etc.)
- Medicare provider number (inpatient institutions only)
- physical location where services were rendered
- provider tax identification number (TIN) – indicate whether employer identification number (EIN) or social security number (SSN)
- remittance address

Inpatient Treatment Information

(Universal Billing form – UB-92 Provider Only)

- all procedures performed (ICD-9 codes and descriptions)

- principal diagnosis (ICD-9 code and description) established, to be chiefly responsible for causing the patient's hospitalization
- all secondary diagnoses (ICD-9 codes and descriptions)
- dates and services (specific and inclusive)
- dates for all absences from a hospital or other approved institution during the period which inpatient benefits are being claimed
- discharge status of the patient
- summary level itemization of billed charges (by revenue codes)

Treatment Information and Ancillary Outpatient Services

(standard billing forms – UB-92 or HCFA 1500 – Provider Only)

- diagnosis (ICD-9 codes and descriptions)
- individual billed charges for each procedure, service, or supply for each date of service
- current procedure codes (CPT-4, HCPCS, ADA) and descriptions for each procedure, service, or supply for each date of service
- specific dates of service

Prescription Drugs and Medicines (standard billing forms when submitted by provider /or Claim for Miscellaneous Expenses available from HAC when submitted by the beneficiary)

- pharmacy receipt to include:
 - date dispensed
 - drug name
 - National Drug Code (NDC)
 - name and address of pharmacy
 - strength and quantity
- on each receipt, write the associated diagnosis legibly

Travel (Claim for Miscellaneous Expenses available from HAC – Beneficiary Only)

- billing statements
- claims for POV mileage to include:
 - certification of medical appointment
 - date of service
 - place of service
 - signature of provider
- other (out-of-pocket) expenses - such as expenses for over-the-counter medicines and supplies (standard billing form -

- Claim for Miscellaneous Expenses available from HAC)
- receipts for all travel expenses (except mileage) for personally owned vehicles (POV)

Filing Deadlines

Claims must be filed with the Health Administration Center no later than:

- one year after the date of service; or
- in the case of inpatient care, one year after the date of discharge; or
- in the case of a VA Regional Office award for retroactive eligibility, 180 days following beneficiary notification of the award

Note: If you pay for care and subsequently file a claim for reimbursement, our payment will be limited to the VA allowed amount. For this reason, you should have your providers bill the HAC directly.

Other Health Insurance (OHI)

While VA assumes full responsibility for the cost of services related to the treatment of a covered birth defect and associated conditions, other health insurers to include Medicare and Medicaid may assume payment responsibility for services unrelated to the VA-covered conditions.

Explanation of Benefits (EOB)

When we finish processing a claim, we will mail you an EOB – even if the claim was filed by the provider. The EOB is a summarization of the action taken on the claim and contains the following information.

- amount billed
- beneficiary name
- dates of service or supplies provided
- description of services and/or supplies provided
- reasons for denial (if applicable)
- to whom payment, if any, was made
- VA-allowed amount

Reconsideration of Claims/Appeals

If you, your representative* or your health care provider disagree with a claim determination, you can request a reconsideration. Include the following in your written request:

- a copy of the explanation of benefits (EOB) in question
- state the specific issue that is being disputed,
- why the VA determination is considered to be in error,
- and include any new and relevant information not previously considered

You must send your request to the HAC within one year of the date of the initial EOB. Send your request to:

VA Health Administration Center
Reconsideration/Appeals
PO Box 469027
Denver CO 80246-9027

We will mail you a written statement of the result of the review if we do not change our original decision.

If you disagree with our decision, you may request a second review. You have 90 days from the date of our first reconsideration to make your appeal in writing. Include the following with your request:

- a copy of the explanation of benefits (EOB) in question,
- state the specific issue that is being disputed,
- why the VA determination is considered to be in error,
- and include any new and relevant information not previously considered.

Send your request to:

VA Health Administration Center
Reconsideration/Appeals
PO Box 469027
Denver CO 80246-9027

**** Must be designated in writing by the beneficiary/legal guardian.***

Glossary

Allowed/allowable amount: The allowable amount (or allowable charge) is the maximum amount authorized for payment to a hospital, institutional provider, physician or other individual medical professional, or an authorized provider for covered medical services.

Approved health care provider: A health care provider approved by the Centers for Medicare and Medicaid services (CMS) formerly known as HCFA, Department of Defense TRICARE program formerly known as CHAMPUS, CHAMPVA, JCAHO, or any health care provider approved for providing services pursuant to a state license or certificate. An entity or individual shall be deemed to be an approved health care provider only when acting within the scope of the approval, license, or certificate.

Beneficiary: A woman Vietnam veteran's birth child who has been determined by a VA regional office to have a covered birth defect.

Child: A birth child of a woman Vietnam veteran, regardless of age or marital status, conceived after the date on which the veteran first served in the Republic of Vietnam during the Vietnam era (February 28, 1961 - May 7, 1975).

CHAMPVA: Similar to TRICARE, CHAMPVA is a federal health benefits program administered by the Department of Veterans Affairs (VA) in which VA shares with eligible beneficiaries, the cost of certain health care services and supplies. Administration of CHAMPVA is managed by the VA Health Administration Center in Denver, Colorado.

Explanation of Benefits (EOB): A statement issued by a health benefits plan/program, summarizing the action taken on a claim.

Habilitative and rehabilitative care: Professional counseling, guidance services, and treatment programs (other than vocational training) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a disabled person.

Health Administration Center (HAC): Located in Denver, Colorado, VA's Health Administration Center is responsible for the administration of various VA benefit programs including the CWWV Health Care Program.

HCFA: Health Care Financing Administration, administrators of Medicare, now called Centers for Medicare and Medicaid Services.

Health care: Home care, hospital care, nursing home care, outpatient care, outpatient care, preventive care, habilitative and rehabilitative care, case management, and respite care. Includes the training of appropriate members of a child's family or household in the care of the child; the provision of pharmaceuticals, supplies, equipment, and devices; direct transportation costs to and from approved health care providers (including any necessary meals and lodging enroute, and accompaniment by an attendant or attendants); and other medical services as determined necessary.

Health care provider: Any entity or individual who furnishes health care, including specialized clinics.

Home care: Medical care, habilitative and rehabilitative care, preventive health services, and health-related services furnished to an individual in the individual's home or other place of residence.

Hospital care: Care and treatment furnished to an individual who has been admitted to a hospital as a patient.

JCAHO: The Joint Commission on Accreditation of Health Care Organizations is the health care industry's quality assurance accrediting body.

Medical supplies: Supplies for medical treatment and/or home care determined to be expendable stock items. Expendable stock items may include catheters, colostomy or ileostomy sets and supplies, plastic or rubber gloves, skin preparation and powders for orthotic and prosthetic appliance wearers, urinals, incontinence supplies, dressing materials, etc.

Nursing home care: Care and treatment furnished to an individual who has been admitted to a nursing home as a resident.

Outpatient care: Care and treatment, including preventive health care services, furnished to an individual other than hospital care or nursing home care.

Preventive care: Care and treatment furnished to prevent disability or illness associated with covered birth defects, including periodic examinations, immunizations, patient health education, and other such services.

Respite care: Care furnished by an approved health care provider on an intermittent basis for a limited period to an individual who resides primarily in a private residence when such care will help the individual continue residing in such private residence.

TRICARE: Formerly known as CHAMPUS. A federal health benefits program administered by the Department of Defense (DoD) for military retirees as well as families of active duty, retired, and deceased service members. DoD shares with eligible beneficiaries, the cost of certain health care services and supplies.

VA Regional Office: Regional centers under VA's Veterans Benefits Administration, the VA branch responsible for the administration for VA benefits other than health care. Among other responsibilities, VA Regional Offices process applications for benefits and determine monetary benefit awards.

Vietnam veteran: A veteran who performed active military, naval, or air service in the Republic of Vietnam during the Vietnam era (February 28, 1961 – May 7, 1975). Service in the Republic of Vietnam includes the waters offshore and service in other locations if the conditions of service involved duty or visitation in the Republic of Vietnam.

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